Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHWEST TEXAS PAIN SOLUTIONS
9402 MESA DRIVE
HOUSTON, TEXAS 77028

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-6335-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "preauthorized services"

Amount in Dispute: $448.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The current dispute involves psychotherapy performed from 09/25/08-10/02/08. The bills submitted to the carrier and the pre-authorization request noted a primary diagnosis of IDD cervical w/o myelopathy and a secondary diagnosis of IDD lumbar w/o myelopathy. Based on…"

Response Submitted by: Flahive Ogden & Latson Attorneys At Law, PC, 50 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2008	CPT code 90806	$122.00	$122.00
September 29, 2008	CPT code 90806	$122.00	$122.00
September 30, 2008	CPT code 90806	$122.00	$122.00
October 2, 2008	CPT code 90806	$122.00	$122.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W12 – Extent of injury. Not finally adjudicated.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - NON-REALTED TO RESOLVED SPRAIN/SRAIN OF 08/04/07

Issues

1. Has the extent of injury issue been finally adjudicated?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds that the respondent denied the disputed services with reason code, "W12 – Extent of injury. Not finally adjudicated." The respondent filed a PLN 11 disputing extent of injury for the following issues: diagnosis of stenosis (narrowing), facet and ligamentum flavum hypetrophy (enlargement or growth) of the lumbar and cervical spine, cyst possible ovarian cyst, or any injury to the pelvic area and the body also cervical and lumbar radioculopathy. A Benefit Contested Case Hearing was held on May 6, 2009. The Hearing Officer's decision and order ruled that, "the compensable injury extends to focal posterocentral 3-4 mm disc herniation C5-6 consistent with an acute protrusion and annular mild kyphotic reversal of the cervical spine apexed at C5-6 attributes to acute disc derangement, right for lateral 3-4 mm contained disc herniation compatible with an active protrusion of recent onset or aggravation given associated annular tear compressing right L4 nerve root marked ligamentum flavum and facet hypertrophy at L4-5, mild hypertrophy on the left L5-S1." Therefore, the extent of injury has been resolved. Review of the submitted documentation finds that the provider rendered treatment to the injured worker for the following: 722.0-Displacement cervical intervert disk without myelopathy; 722.10-displacement lumbar intervert disc without myelopathy; 728.85-Spasm of muscle; and 847.1-Thoracic sprain/strain. Therefore, the extent of injury issue has been resolved and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(b) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(7) requires preauthorization of "all psychological testing and psychotherapy…" Review of the submitted documentation finds evidence to support that the provider obtained preauthorization for the disputed services prior to providing the health care.
3. Per 28 Texas Administrative Code, Section §134.203(b) and (c), for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers. To determine the MAR (maximum allowable reimbursement) for professional services, system participants shall apply the Medicare payment policies with minimal modifications; for service categories of Evaluation Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. The MAR for CPT code 90806 in Harris County is as follows: DWC conversion factor of $52.83 divided by Medicare conversion factor of 38.087 = $1.387 X Participating Amount of $93.15 = $129.21 X 4 DOS = $516.84. The requestor's *Table of Disputed Services* lists the amount in dispute as $488.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $488.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $488.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.